# PROFESSIONAL VERIFICATION FORM

**For transportation service provided by the City of Watertown Paratransit system**

**To be completed by a physician or health care professional**

**Dear Physician/Trained Professional:**

**Your patient/client has made an application to the City of Watertown for eligibility for Paratransit service. In order for the application t be complete, certification regarding the patient's physical/mental disability is required. Please complete all questions below. All requested information that you provide in this application will be kept CONFIDENTIAL and will not be released to any person, agency or organization. The City is soliciting this information SOLELY for the purpose of establishing eligibility for the City's Paratransit Bus System whose purpose is to serve those who are unable to use the fixed route CitiBus service provided.**

**It is necessary that you certify that your patient/client cannot use the fixed route bus service by verifying the nature of the disability as indicated below. (If mental disability, a statement from a trained medical professional is recommended. Also, please indicate whether or not your patient/client, due to behavioral abnormalities, could possibly harm themselves, other passengers or the bus driver.**

## ELIGIBILITY CRITERIA

**Registration is limited to disabled persons of all ages who are physically or mentally unable to access the regular bus system and who can meet on or more of the following criteria:**

- **A. Inability to get on or off a fixed route public transit bus**
- **B. Inability to walk from home to the nearest bus stop**
- **C. Inability to grasp coins, tickets or handles**
- **D. Inability to read, understand or follow bus information**
- **E. Inability to utilize a regular public transit bus in the performance of a life-sustaining activity.**
- **F. Inability to use the regular transit system for reasons other than mobility, such as persons with severe epileptic seizures.**

**Please complete the following:**

**Name of Applicant: _____**

**Capacity in which you know the applicant: _____**

**Medical diagnosis of condition causing the disability: _____**
**_____**

**Is this disability temporary? _____YES _____NO**
**If YES, then what is the duration applicant will need Paratransit services:**
**_____**

**With your knowledge of the applicant's disability and your professional opinion, which of the following best describes their transportation ability? Please select one:**

**A ____ my patient/client has the ability to use the CitiBus fixed route (regular bus) system without restrictions and does not need Paratransit services**

**B ____ my patient/client has the ability to use the CitiBus fixed route (regular bus) system for some of their needs. (Applicant would require Paratransit service only part of the time, for example, during winter months)**

**C ____ My patient/client does not have the ability to use the CitiBus fixed route (regular bus) system for any travel needs and will be restricted to using the Paratransit System (lift equipped bus) exclusively.**

**D ____ my patient/client does not have the ability to use the CitiBus fixed route (regular bus) system OR the Paratransit system due to one of the following reasons:**

- **My patient/client is unable to get to the curb without assistance ****
- **My patient/client is unable to ride the bus in a seated position**
- **My patient/client requires ambulance services for his/her medical needs during transport**

****Applicants unable to reach the curb alone, who are accompanied by their own personal care attendant, are eligible to ride.**

**Is there any other effect of the disability which CitiBus should be aware? Please describe:**

**_____**

**_____**

**Your Name:_____**
**Title/Degree:_____**
**Address: _____**
**Phone # _____**
**Signature:_____ Date: _____**

**Please mail completed form to:**

CitiBus Paratransit Services
c/o Guilfoyle Ambulance Service Inc
PO Box 88
Watertown NY 13601
ATTN: Jeffrey Lieberman